Presentation on Mental Health Issues to House Health Policy Committee
February 17, 2011 – Mark Reinstein, Ph.D., Mental Health Association in Michigan

Representative Haines and Members of the Committee,

I'm Mark Reinstein, President & CEO of the Mental Health Association in Michigan, now in its 74th year as the state's oldest non-profit organization concerned with mental health issues. We are affiliated with Mental Health America (Alexandria, Virginia) and partly funded by local United Ways. I am in my 29th year with the Mental Health Association. We have always been – and remain – a policy analysis and government-relations organization on behalf of individuals experiencing mental illness. We are also the co-founder of a broad statewide coalition (*Michigan Partners in Crisis*) on mental health-and-justice issues because so many of our constituents are winding up in justice settings.

Thank you for the invitation to present to you today on mental health policy issues. Our state faces grave difficulties in this area. Some of the matters I'll discuss are not necessarily going to fall in your Committee's purview, but I think it's important that I give you a picture of everything we're facing.

When Governor Granholm in 2004 first addressed her special Mental Health Commission, on which I served, she said mental health in Michigan was "broken." If it was broken then, it certainly still is today, in part because state government has essentially ignored the Commission's report and recommendations.

Based on the best national studies that have been done, we know that one in two U.S. adults has experienced some manner of psychiatric disorder in their lifetime. From those studies, we can also conservatively project that 25% of adults and 20% of minors are experiencing some manner of mental illness in any 12-month period. In Michigan, that would translate to 1.9 million adults and 470,000 minors. We further know that at least 5.5% of the adult population is experiencing potentially severe mental illness such as schizophrenia, bipolar disorder and major depression, and some 10% of youth have emotional disorders that significantly interfere with their ability to function at home, school and in the community. Those percentages translate to 418,000 adults and 235,000 minors in our state with potentially severe mental illness.

Where are all these people served?

An unknown number are served in the private sector, but that sector doesn't have to do its full fair share in dealing with these problems, something I'll discuss in more detail shortly.

Michigan's publicly funded mental health system, which has many problems of its own, claims to annually serve through Community Mental Health (CMH) programs 150,000 adults with mental illness and 40,000 minors with emotional disturbance. This system also serves persons with developmental disabilities, who constitute under 20% of its

clients, and a very small number of persons with substance abuse disorders, as the primary public service vehicles for such disorders are regional substance abuse coordinating agencies. My organization is a mental illness organization, and that is our focus. It is a critical focus, given that over 80% of CMH clients are persons with mental illness, and the number of CMH mental illness clients has grown by 20% since the year 2000.

The Department of Community Health (DCH) also says that a little over 50,000 Michiganders annually receive mental illness service through publicly funded Medicaid HMOs, and that less than 20,000 a year use Medicaid to pay for mental illness service through a private practitioner.

Add all these numbers up and we have 260,000 Michiganders annually getting some manner of publicly funded mental illness service. How many of these are potentially severe cases? People responsible for the public system say the cases are all "serious" because state law defines "serious mental illness" and "serious emotional disturbance" in hugely broad ways. But any independent observer looking at the diagnoses reported for publicly funded clients would be hard-pressed to conclude that the public system exclusively serves cases of the highest potential severity.

When we combine public system numbers and shortcomings with the legally sanctioned deficiencies of the private-pay sector in Michigan, the bottom line is that many of the 1.4 million with annual psychiatric disorders, and many of the 650,000-plus with potentially severe conditions, aren't getting any care and treatment for their mental illness. In fact, national studies have documented that over half of those with severe disorders do not receive treatment.

Persons with severe mental illness, and most especially those not receiving treatment for it, are at grave risk for homelessness, justice system incarceration, which I'll discuss in more detail later, and early death, as it has been documented that people with severe mental illness lose 25 years of life compared to the rest of the population.

There's one other critical point to make about severe disorders. Treatment of them almost invariably involves medication. The federal government documented a few years ago that, among adults getting treatment for major psychological distress resulting from mental illness, 87% were receiving medications. In fact, 35% were receiving only medications as their course of treatment. Advances in mental health medication, more than any other factor, are what have enabled society to try treating mental illness in the community. Yet there is great variability among individuals in terms of what drugs work for whom. I bring all this up because Michigan has had a law since 2004 promoting open access to mental health medications in the Medicaid program. DCH has projected at times since then that we could "save" $5 million General Fund if access to those medications were more restricted. That would be penny-wise and pound-foolish, and the supposed savings to be gained from restrictions (if anyone is going to propose them this budget cycle) would be outstripped by ensuing expenditures for more hospitalizations, emergency room visits, incarcerations, job losses, home losses and other consequences.

Let's take a closer look now at problems of the private and public mental health sectors in Michigan.

In the private sector, the big problem is that we're one of only seven states left that still legally allow private insurance discrimination against mental illnesses, forcing some to pay much more out-of-pocket for mental health than other medical care, and permitting insurers to offer significantly fewer benefits for mental illness than for other health conditions.

The federal mental health parity law of 2008 certainly lessened the problem, but it doesn't cover approximately 1.5 million privately insured Michiganders – i.e., those who have coverage through a business employing less than 51 people. (It also excludes individual policies.) And while some say last year's federal health care reform act will further lessen the problem come 2014, there are too many unknowns about that act's future and implementation to state with certainty its degree of help on this issue. Michigan needs to join the other 43 states that have adopted their own mental health parity law so we can fill in existing and potential holes in the federal laws.

Why do we lag behind so many states when it comes to parity? Because the business community (as it had in all these other states) and the UAW (unlike what happened in those states) oppose parity law in Michigan. They say that's because of fear about potential cost, but the opponents of parity in Michigan know its cost is negligible, if anything. What they really fear is that if this law about workplace-related coverage gets through, that will make it easier for future laws about workplace-related coverage to get through.

Here are some critical summary points about mental health parity:

- It has been overwhelmingly documented in recent years that the short-term direct cost of parity is less than one percent, and this can easily be offset by improved worker productivity, less employee absenteeism and reduced use of emergency rooms and other health care resources.

- Not one of the 43 states with parity law has ever found it necessary to repeal its law, and this includes several states that had automatic sunset provisions about cost increase triggers. Additionally, some of the parity states have actually strengthened their initial laws over time.

- The mental health parity bills proposed for Michigan do not require employers to offer mental health coverage. Rather, they state that if an employer elects to do, the benefits and customer cost-sharing arrangements for mental health must be comparable to what is offered for other medical care.

•Ongoing national probability sampling conducted by Ronal Kessler, one of the nation's leading mental health researchers, has found that mental illness accounts for about $200 billion in lost earnings annually in the U.S. Building on Kessler's work, another researcher factored in mental health care expenditures and disability benefits, bringing the annual figure to over $300 billion. And this figure does not include costs of incarceration, homelessness or several other consequential factors associated with mental illness.

•Children are especially hard hit when treatment for mental illness is arbitrarily restricted. A recent federal report with information for the year 2007 found that only 50% of children with mental health conditions had private insurance coverage, compared to 64% of children without these conditions.

•In a new federal study taking us through the year 2005, national spending on mental health accounted for only 6.1% of all U.S. health care expenditures and was going downward as a proportion of health care spending. The study also found that private insurance was devoting only 4.4% of its health care expenditures to mental health, whereas Medicaid was spending 10% on mental health.

Everyone familiar with mental health in Michigan bemoans how we can't get to people with mental illness in the early stages of their disease. The only realistic hope for doing that in the foreseeable future is to see that the private sector does its fair share regarding mental health service, and that means state parity law.

One last point about parity. You're not only going to hear from people who want mental health parity, but you're also going to hear from individuals who want a law improving private insurance coverage of autism. Close to half the states in the union have some manner of autism coverage law. While autism is not a mental illness, it is in the parlance of the field a neuropsychiatric disorder, and the overwhelming majority of the mental health community would like to bring you legislation that protects both mental illnesses and pervasive developmental disorders such as autism. Whether the voices that are strongest for autism legislation would agree to a combined approach, as opposed to totally separate legislative vehicles, remains to be seen.

Turning to the publicly funded sector, it is a system dominated by our state's Community Mental Health Services Programs (CMHSPs). It's a system that is too decentralized; inefficiently organized; too disparate; lacking in accountability; and sorely lacking in what it spends on mental illness.

Some observers think that various socioeconomic health care forces will mean an end to the existence of CMHSPs in 5-10 years. Maybe that's true. But maybe it isn't. I've been around long enough to know that you don't assume things are going to go back to "ground zero" to start over, and if there are problems in a system you had better propose solutions fitting that system rather than saying let's wait for it to blow up.

In the time available to me, I'll discuss six specific major problems of our existing publicly funded mental health sector:

1) We have too many CMH programs, and they are organized in a non-transparent way. There are presently 46 CMHSPs. Eighteen of them sign contracts with the state for both Medicaid and non-Medicaid service. The other 28 sign state contracts only for non-Medicaid service and have to find one of the 18 "Medicaid" CMHSPs to subcontract with for Medicaid. Then local service providers have to be brought into the picture, and in some communities CMHSPs contract with separate entities to manage local providers instead of doing it themselves. The CMH system is a maze of contracts, subcontracts and sub-subcontracts. In today's technological world, we don't need 46 CMHSPs. We should consolidate to 18; have those 18 responsible for both Medicaid and non-Medicaid service; and have those 18 directly mange services in their assigned geographic areas, which can be configured to still cover the whole state. At a time when everyone is talking about consolidating school districts, municipal services and a host of other things to save money, why is no one talking about consolidating CMH programs? We will have a draft bill ready on this soon.

2) At any given time, half or more of CMH mental illness clients are not enrolled in Medicaid, yet since the late '90s we have devoted 20% or less of CMH appropriations to service for non-Medicaid clients. This has created a two-tiered mental health system where Medicaid enrollees have a chance of getting service while persons not in Medicaid have much slimmer odds of being accepted, and more and more are simply being turned away in violation of state law. The federal health care reform act, if it remains in existence, will help here by the year 2014 in that Medicaid eligibility and coverage would be expanded to new categories of individuals. But if that law goes away, then this issue remains one that Michigan must address.

3) Among the priorities for public mental health service under Michigan law are adults with the "most severe forms" of mental illness and children with the "most severe forms" of emotional disturbance. But there is no statewide regulatory definition of what "the most severe" forms of these conditions are. Each CMHSP may decide for itself. In a system primarily funded by the public's state and federal taxes, that is an open-ended invitation to unequal treatment across the state, and we must have a uniform Michigan operationalization of severity. We will have a bill ready for introduction on this soon.

4) Our CMH programs have far too much control over whether someone is a current threat to self or others and needs involuntary mental health treatment. Someone has to be the arbiter of that decision, and in our society people want and expect it to be the courts, not an entity that would have to pay for any services deemed necessary. But since 1995, state law has set things up so that these decisions are often made by CMH pre-admission screening units, which don't have to apply the same criteria that courts would and don't have to inform courts of their decisions. Additionally, even if someone winds up before a court and an involuntary treatment order is issued, state law allows CMH programs to in effect undo those orders. And as bad as the situation is for adults, it's even worse for children. Since 1984, state law has prohibited courts except in narrow circumstances to

order a youth psychiatric hospitalization if the local CMH program does not agree. Is it any wonder that we have so many severely disordered individuals, desperately in need of treatment, left to their own devices and winding up homeless, jobless and in the justice system? We are presently drafting a bill on this.

5) Our public mental health system promises service applicants and recipients a wealth of rights, but delivers on few of them. If you're in Medicaid, you can take a service grievance before an administrative law judge, but that law judge (unlike a court in a civil hearing) is not required to seek independent consultation from a mental health clinician before rendering a decision. If you're not enrolled in Medicaid, then your local CMH program is judge and jury for any service complaints. We also have recipient rights programs for non-service complaints, but the state Recipient Rights Director isn't independent of the Department of Community Health, and the CMH Recipient Rights Directors work for the CMH Executive Directors. Nothing can make our system more accountable – and effectively empower consumers and families – than effective grievance, appeal and rights mechanisms. If we can't or don't want to do that, let's start eliminating the illusory rights tools that we promise people today. We'll soon have some bills ready on this front and would be glad to work with any member of the committee who is interested in introducing and advancing them.

6) Our public mental health system is underfunded, with one affected area being the non-Medicaid side. This line item, which has been going down in recent years, has only $280 million in it for FY-11. And remember, at any point in time, roughly half of CMH clients in Michigan are not in Medicaid. But the overall situation, even with Medicaid included, is not a good one for adults and minors with mental illness. In last year's demographic and service report to the Legislature, DCH reported that the average annual CMH expenditure per adult mental illness client was $5,374. For a child mental illness client, the figure was $3,481. The average annual CMH expenditure for a developmental disability client was $25,733. In noting this, I'm not suggesting that developmental disability expenditures are inappropriately high or should be reduced. (I would, however, suggest we need to do what most states have done – i.e., recognize that mental illness and developmental disability are vastly different conditions with vastly different needs and have separate state-level structures for their respective service management and oversight.) My point in raising the per-client expenditures is to remind you that the vast majority of public mental health system clients are persons with mental illness, and what we spend on them is not sufficient to meet their needs.

My last goal today is to leave you with a sense of the tremendous problem we face today of persons with mental illness entering justice systems – juvenile justice facilities, local jails and state prisons. There is a mountain of national and state evidence that in our country and in Michigan we have an epidemic of persons with mental illness in our justice systems. Many of these people have committed relatively minor offenses that would not have happened if they were receiving treatment for their condition. Many of these people in the past would have received psychiatric hospital stays of more than short-term length, but that is almost unavailable anymore. (Private and community hospitals offer only short-term stays, and the state only operates three psychiatric

hospitals for adults and just one for children.) When we put huge numbers of persons with mental illness in justice systems, we are greatly overburdening those systems, the courts and law enforcement, and we are placing highly disordered individuals in environments that are totally non-therapeutic, no matter what degree of treatment is attempted.

One piece of Michigan evidence we have is a 1998-99 study of the county jails in Wayne, Kent and Clinton by independent clinicians from Wayne State University. The investigators found that over 50% of the inmates in these jails had mental illness, and 34% had one of the "big three" severity diagnoses – i.e., bipolar disorder, major depression or psychotic disorders (including but not limited to schizophrenia).

More recently, the University of Michigan released last April an independent study of state prisons. That study found the following:

- Over 20% of prisoners had active symptoms of severe mental disorders. The investigators noted that the numbers would have been much higher if they were documenting moderate disorders, not just severe ones.

- Of the 20-plus percent of inmates with severe disorder symptoms, prison records could document that only one-third had received specialized mental health service in the previous 12 months.

- Among prisoners receiving some manner of mental health service, 41% had experienced at least one previous psychiatric hospitalization.

If anyone wants to talk about saving money in corrections, we had better be attentive to the fact that society now uses correction facilities as today's mental health "institutions." While some solutions for this problem may better fall under the purview of other House committees or subcommittees, one matter this committee may wish to consider is legislation establishing statewide standards and expectations for community jail diversion programming. The *Partners in Crisis* coalition we administer will have a draft bill ready to go on this soon, a bill that is flexible and does not mandate local expenditures that communities cannot afford to make.

Mental illness services in Michigan are in a crisis. To the degree that solutions require more spending, it isn't going to be forthcoming in Michigan right now. But there are a number of things that can be done without additional expenditures, and there even a few things we can do that will immediately save money in the short-term budget cycles that constitute the legislative and state government fiscal world. Policies and structures that were put in place 20, 30, 40 and in some cases even 50 years ago to meet circumstances and technologies that then existed now need major re-tooling to fit circumstances and technologies that exist today. I have tried to give you a sense of some issues to be tackled and steps to be taken if we choose to follow that road. Thank you for the opportunity to present to you today. I look forward to working with the Committee.

Summary, Important Data, Mental Health in Michigan

with Mental Illness in Any 12-Month Period: 1.9 million adults and 470,000 minors

with Severe Mental Illness: 418,000 adults and 235,000 minors; less than 50% receive treatment; among adults getting treatment, almost 90% on medications; 25 years of life lost compared to rest of population

Individuals Served by Community Mental Health (per DCH 2010): 181,000 mental illness (20% increase in ten years); 28,600 developmental disability; 11,000 combined mental illness-and-developmental disability

#Individuals Receiving Mental Illness Service via a Medicaid HMO (per DCH 2004): 52,000

#Individuals Seeing a Mental Illness Fee-for-Service Practitioner Paid by Medicaid (per DCH 2004): 19,000

# of States without a Mental Health Insurance Parity Law: Michigan and 6 others

Premium Cost Increase Attributable to Mental Health Parity: Less than one percent (can be easily made up via positive cost offsets)

# of Privately Insured Michiganders Not Covered by the 2008 Federal Mental Health Parity Act: 1.5-2.0 million

National Cost of Mental Illness from Lost Earnings, Mental Health Care Expenditures & Disability Benefits: Well over $300 billion p/year (Does not include costs of incarceration, homelessness over several other mental illness consequences)

National Spending on Mental Health Care, 2005: 6.1% of all health care expenditures; mental health trending downwards; private insurance = 4.4% spending on mental health compared to 10% mental health spending by Medicaid (While many states had parity law by '05, federal statute prevented the state laws from applying to self-insured [large] employers. These employers were brought in by the federal parity act of '08, which took effect in 2010.)

CMHSPs in Michigan: 46; eighteen are both Medicaid and non-Medicaid; the other 28 have to subcontract with one of the Medicaid-18 for Medicaid funding

Population and Spending Percentages re CMHSP non-Medicaid: Historically, 50% of clients but since late '90s, less than 20% of amount appropriated to Community Mental Health

CMHSP Annual per/Client Spending (source = DCH): Adults with mental illness: $5,374; Children with mental illness: $3,481; Individuals with developmental disability: $25,733

Wayne, Kent & Clinton Jail Inmates with Mental Illness, 1998-99 (Wayne State University): Over 50% (34% severe diagnoses)

State Prison Inmates with Severe Mental Disability, 2010 (U-M): Over 20%, only one-third of whom could be documented as receiving specialty mental health service the previous 12 months; 41% of prisoners receiving mental health service had previous psychiatric hospitalization(s)